

Self-Screening Checklist  
*Draft 12/16/02*

**SMALLPOX (VACCINIA) VACCINE  
CHECKLIST**

Please read and fill out the information below to the best of your ability.

**Medical History:**

Allergies to Medications: Yes ☐ No ☐ If yes, please list medications: \_\_\_\_\_

**Do any of the following conditions apply to YOU?**

Yes No Don't Know

- |                          |                          |                          |  |
|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Immune system problems such as HIV/AIDS, cancer, leukemia, lymphoma, organ transplant, agammaglobulinemia;   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Autoimmune diseases like lupus that may weaken your immune system;   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Currently taking immunosuppressive drugs such as oral steroids (such as prednisone), chemotherapy agents/radiation, or organ transplant medications. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Eczema or atopic dermatitis, or a history of these conditions  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Other skin conditions such as burns, impetigo, contact dermatitis, or varicella zoster.  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Currently Pregnant, breastfeeding, or planning to become pregnant in the next month  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Allergy to antibiotics polymixin B, streptomycin, chlortetracycline, neomycin  |

**Do any of the following conditions apply to YOUR HOUSEHOLD MEMBERS OR CLOSE PERSONAL CONTACTS?**

Yes No Don't Know

- |                          |                          |                          |  |
|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Immune system problems such as HIV/AIDS, cancer, leukemia, lymphoma, organ transplant, agammaglobulinemia;   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Autoimmune diseases like lupus that may weaken your immune system;   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Currently taking immunosuppressive drugs such as oral steroids (such as prednisone), chemotherapy agents/radiation, or organ transplant medications. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Eczema or atopic dermatitis, or a history of these conditions  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Other skin conditions such as burns, impetigo, contact dermatitis, or varicella zoster.  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Currently Pregnant or planning to become pregnant in the next month  |

If you have checked "Yes" to any of the above questions, you should not receive smallpox vaccine at this time.

If you have checked "Don't Know" to any of the items on this form, we strongly recommend that you seek advice and any necessary laboratory testing from your private health care provider prior to continuing the enrollment process.

If you decide to proceed with the enrollment process for vaccination, you will be asked similar questions again when you report on vaccination day to assess your eligibility to receive the vaccine.